Termination of Wage Loss Award

(formerly: Agreed Statement of Fact)
Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

SEE INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employer

Name of employer (see Employer's First Report)		Address
Phone number	Federal Tax Identification Number	

Employee

Name of employee		Address
Phone number	Social Security Number	

Terms of Agreement

Payments of compensation under the outstanding award for the accident occurring on _____ are terminated for the reason indicated below.

1. ☐ **The employee returned to work on _____ at a wage equal to or greater than the pre-injury average weekly wage of $_____.**

2. ☐ **The employee was able to return to his/her pre-injury work on _____.**

3. ☐ **The employee returned to work on _____ at a lower-than-pre-injury wage in the amount of $_____. (A Supplemental Agreement to Pay Benefits must be attached and the outstanding award will be terminated and an award for temporary partial benefits will be entered.)**

TOTAL AMOUNT OF COMPENSATION PAID THROUGH ABOVE DATE $ _____

TOTAL COST OF LIVING ADJUSTMENT PAID THROUGH ABOVE DATE $ _____

This agreement is subject to the Commission's approval. Signing this form is NOT a requirement for payment of compensation, and does not terminate the right to future compensation. See "Employee" section on the reverse of this form.

(This space for Commission use only)
Approved by: Date:

(This space reserved for use by the insurer or employer)

Payment type	Compensation rate	Beginning date	Ending date	Total weeks paid	Amount paid
_____	$ _____	_____	_____	_____	$ _____
_____	$ _____	_____	_____	_____	$ _____
_____	$ _____	_____	_____	_____	$ _____
_____	$ _____	_____	_____	_____	$ _____

Signature of Employee, guardian, or committee	Date	Print Name	Phone ( )
Insurer or authorized representative (signature of processor)	Date	Print Name	Phone ( )

Name of Insurer	Third Party Administrator and Address (if applicable)

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Termination of Wage Loss Award
VWC Form No. 46

Insurer or authorized representative

1. This form is completed when the employee returns or was able to return to regular or light-duty employment. This form should also reflect compensation payments and or Cost-of-Living Adjustments that were paid to or on behalf of the employee. Submit the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond VA 23220.

2. The information at the top right of the form should be provided by the insurer. Please note that the insurer code refers to the five-digit numeric code assigned by The National Counsel on Compensation Insurance (NCCI). Self-insured employers are assigned a similar five-digit code number by the Virginia Workers' Compensation Commission.

3. Either incomplete or illegible forms will be returned to the insurer for proper completion or they will be rejected.

4. "Terms of Agreement":

   - Check the appropriate reason for the termination of the Award and provide the return to work date and wage information, if applicable.
   - When block number 3 is marked, a Supplemental Agreement to Pay Benefits (VWC Form No. 4A or 4G) must be attached. Forms received without specific dollar amounts or those that reflect the word "Various" will be rejected.
   - When block number 3 is marked and a Supplemental Agreement to Pay Benefits (VWC Form 4A or 4G) is not attached, the current Award will remain outstanding.
   - Provide the file totals through the date of return to work to reflect the total amount of compensation and Cost-of-Living Adjustments paid in the case.
   - If the basis for terminating benefits is for reasons other than what is contained on this form, you may need to file an Employer's Application for Hearing (VWC Form No. 5A) to terminate the outstanding Award. This form may not be modified to meet a specific case, or the form will be rejected.

5. In the space reserved for use by the insurer or employer at the bottom of the form, a detailed summary of payments should be provided for each period of disability with the information requested.* *Note*: You do not need to report payments that have been previously reported to the Commission. If additional space is needed, use a separate sheet of paper with the same column headings and this document should also be signed by all of the parties to the case.

6. When reporting multiple periods of compensation that are not consecutive, a separate Termination of Wage Loss Award (VWC Form No. 46) should be provided reflecting each return to work date under the "Terms of Agreement". The breakdown of benefits at the bottom of the form is not sufficient to terminate an award.

7. The signatures of the employee and a representative of the employer or insurer (including the insurer's name) are required. If these signatures are missing, this form will be returned.

8. **Forms**: Additional copies of this form are available without cost by writing to the Commission. This form is also available on the Commission's Website at www.vwc.state.va.us. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Address your inquiries to "Forms" at the listed Virginia Workers' Compensation Commission address.

Employee

The signing of this document is not a requirement for payment. If you do not agree with the "Terms of Agreement", and make modifications to the form, the form will be rejected. Should you have any further disability, your claim can be reopened with the following limitations:

1. If the claim is for wage loss benefits, your claim must be reopened within 24 months from the last date for which you were entitled to compensation paid under an Award.

2. If the claim is for permanent disability, your claim must be made within 36 months from the last date for which you were entitled to compensation paid under an Award.

---

*The valid payment types are:

TT	Temporary Total
TP	Temporary Partial
PP	Permanent Partial (specific disability)
PT	Permanent Total
LS	Lump Sum
CL	Cost-of-Living
FT	Compensation paid in a fatal claim
FE	Funeral expense

For questions or assistance with completing this form, please contact the Awards Unit using the Commission's Toll-Free number at (1-877) 664-2566.